Washington State Health Care Authority

Universal Health Care Commission Meeting Summary

April 14, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the Commission are available on the Universal Health Care Commission webpage.

Members present

Vicki Lowe, chair
Bidisha Mandal
Dave Iseminger
Senator Emily Randall
Jane Beyer
Joan Altman
Representative Joe Schmick
Karen Johnson
Representative Marcus Riccelli
Mohamed Shidane
Nicole Gomez
Stella Vasquez

Members absent

Senator Ann Rivers
Estell Williams
Kristin Peterson

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 3:03 p.m.

Agenda items

Welcoming remarks

Ms. Lowe welcomed the members of the Commission and the public to the fourth meeting of the Universal Health Care Commission.

Meeting Summary review from the previous meeting

The Commission Members present voted by consensus to adopt the Meeting Summary from the Commission's February 2022 meeting.

Public comment

Ms. Lowe called for verbal and written (via the Zoom chat) comments from the public.

Kelly Powers, a Cascade Care enrollee, urged that the Commission's report to the Legislature (due November 2022) should include the Universal Health Care (UHC) Work Group's financial analysis of Model A (state-governed, state-administered), particularly the $5.6B in estimated annual savings. She also noted that though uninsured rates have decreased, the number of underinsured Washingtonians has increased. (Verbal)

Lynette Vehrs, Registered Nurse and President of the Washington State Nurses Association remarked that nurses want universal health care. She shared that in her nursing practice, it was emotionally painful to care for patients who were denied medication or procedures due to lack of health care coverage. (Verbal)

Cris Currie, retired Registered Nurse, encouraged the Commission to work promptly with Health and Human Services (HHS) to the develop a 1332 waiver. He suggested that waiver authority can be granted prior to finalizing a single-payer funding plan, and that the Commission should determine the projected amount of passthrough funding from the 1332 waiver, as this information may it easier to pass the necessary legislation. (Verbal)

Roger Collier urged the Commission to read his written proposal for the Washington health care plan which combines two of the goals of the Commission; 1) to make immediate and impactful changes to the current health care system, and 2) to take the first steps toward a universal financing system. He asked Commission Members to consider letting him read his full proposal at a future Commission meeting. (Verbal)

Pam Dalan, Registered Nurse, remarked that 25-30% of the current health care budget is dedicated to administration. She called on the Commission to work on creating a finance committee and consider the formation of an ad hoc committee to make recommendations on the finance committee formation. She also asked for further transparency regarding consultants engaged to work with the Commission. (Verbal)

Marcia Stedman, Board Member for Health Care for All Washington, remarked that it is impossible for the costs of universal health care under a publicly administered system to be more costly than our current system. She recommended that the Commission move quickly to form an ad hoc committee to make recommendations for the creation of a finance committee. (Verbal)

Maureen Brinck-Lund commented that the chart on page 69 (of the meeting materials) describing Models A-C only displayed the estimated savings for the implementation year. She noted that Model A generates $5.6B in savings annually past the implementation year. (Verbal)

Kathryn Lewandowsky, Registered Nurse and Vice-Chair of Whole Washington, stated that true health care reform has been a topic of discussion for decades in each election cycle and has never been achieved. She remarked that the COVID-19 pandemic has exposed the disadvantages and shortcomings of the current for-profit health care system. (Verbal)

Presentation: Evan Klein, Special Assistant for Policy and Legislative Affairs, Health Care Authority (HCA), and Jane Beyer, Commission Member and Senior Health Policy Advisor with the Office of the Insurance Commissioner (OIC), shared updates from the 2022 legislative session.

Mr. Klein shared that 2022 was a short legislative session and a supplemental budget year. The state's revenue increased by over $5B, and the Health Care Authority's budget increased by over $1.5B. HCA's increased funding is designated for various HCA programs as well as the creation of new programs, which also includes provider rate increases. HCA analyzed over 200 pieces of policy legislation and received over 55 new legislative reporting requirements.

At least two bills will have a significant impact on HCA and may be relevant to the work of the Commission. The first, Senate Bill 5589 (primary care expenditures), directs the Health Care Cost Transparency Board to analyzing progress towards spending 12% of total statewide health care expenditures on primary care. The second, Senate Bill 5532 requires the Prescription Drug Affordability Board to identify and conduct affordability reviews of drugs that have been on the market for 7 years and meet certain criteria. The Board is also authorized to set upper payment limits for up to 12 drugs beginning in January 2027. Other directives for HCA in the budget proviso include the following: standing up a new coverage program for individuals earning under 138% of the Federal Poverty Level (FPL); funding for continuous enrollment for children up to age 6; and a suite of provider reimbursement rate increases.

Ms. Beyer shared three bills, of which the first two were high priorities for consumer advocates regarding commercial health insurance. The first, House Bill 1688 (balance billing), passed with bipartisan support and broadens the scope of services protected from balance, or "surprise" billing. This bill also prohibits hospitals and providers from requiring patients to waive their balance billing protections. A provision of this legislation allows individuals with a behavioral health emergency to receive services regardless of whether the provider issuing services is in-network of the individual's health care coverage/plan.

Senate Bill 5610 (specialty medications/"co-pay accumulator bill") is the second high priority bill for consumer advocates regarding commercial health insurance. This bill directs private health plans to count the value of third-party payments, including manufacturers' coupons, toward a consumer's health plan deductible and their maximum out-of-pocket if, 1) a drug doesn't have a generic equivalent or a therapeutic equivalent that's a preferred drug on their health plan's formulary, or 2) if a consumer has been able to have a drug covered as an exception process.

The third bill updated coverage of audio-only telemedicine (House Bill 1821). This legislation revised the requirement that the patient have an established relationship with the provider issuing audio-only telemedicine services before the audio-only telemedicine will be covered by insurance.

Presentation: Dan Meuse, Deputy Director of State Health and Value Strategies at Princeton University, shared Federal Coverage Structures and Hurdles for State-Run Financing Systems.

Mr. Meuse outlined the various methods of coverage for individuals post-Affordable Care Act (ACA):

- Medicare – 65 and over, some disabled
- Medicaid – Available to individuals under 138% of FPL (except undocumented individuals)
- CHIP (Children's Health Insurance Program) – Available to lower-income children
- Self-Marketplace coverage (except undocumented individuals)

- Employer – Most, though not all employers offer coverage to full-time employees

Mr. Meuse shared that Medicare is likely the largest hurdle for a state-run health system. Medicare represents the single largest revenue line for most hospitals and functions the same across the country. Additionally, funding decisions for Medicare are completely under federal control. However, if Washington can find savings in Medicare, then this savings could fund coverage for other population groups. Maryland and Pennsylvania have some level of control over Medicare payments for hospitals through a CMMI (Center for Medicare and Medicaid Innovation) waiver.

- For over 40 years, Maryland has had an agreement with the federal government to set rates for hospital reimbursement in the state's health care system. In 2014, Maryland engaged with CMMI to implement a statewide waiver allowing the state to set rates for Medicare payments (in the ACA context) and leverage savings from the rate setting under the waiver into other population health opportunities.
- Pennsylvania allows rural hospitals to opt into a waiver-based payment program that transitions payment away from fee-for-service to a global budget.

Medicaid and CHIP are a federal/state partnership where funding decisions are generally under state control subject to some federal constraints. Eligibility for these programs is often income-based, though states can apply for "demonstration waivers" to add populations and change funding and payment models. However, the federal government must approve changes to Medicaid programs which may impact the state's ability to innovate depending on the current administration. While Medicaid has some flexibilities, the program pays providers less than Medicare and commercial insurance.

The individual market is a federal, state, and private market partnership, where states can regulate coverage, but federal dollars are critical for affordability. There are limits on how states can innovate in their individual market and the individual market relies on the current insurance system.

The employer market is protected by a federal law called ERISA (Employee Retirement Income Security Act, 1974) and is likely impenetrable without some level of legislative change. The two models for employer-sponsored coverage include the fully insured model and the self-insured model. A large multi-state employer is usually self-insured so they can contract with a large, national carrier to provide coverage to their employees. The employer market represents the largest pool of portable dollars because employers overpay for services as compared to public programs.

Federal authority lives in three departments including Health and Human Services, the Treasury, and the Department of Labor. The agencies under these respective departments have varying levels of flexibility for transitioning to a unified funding model. Flexibility is most generous for Medicaid, the marketplace, and premium tax credits. There is moderate flexibility in Medicare and COBRA. The areas with limited flexibility are ERISA, employer health insurance exclusion, Federally Qualified Health Centers, and hospital payments.

Even programs with ongoing flexibility have constraints and the model of flexibility looks different to federal officials than to state officials. Crafting a payment model will be the greatest challenge. There is no single payment structure that can be used for all services. Additionally, managing a budget will likely require payment model innovations, including global budgeting which requires provider system participation.

Mr. Meuse noted that the current system was built and designed with structural racism at its root. For example, Medicaid was limited to certain income levels and pays providers less than other providers. In its pursuit of a new

health care delivery and financing system, Washington must ensure that it is equity centered to create a model in which the remnants of racism are eliminated.

Presentation: Liz Arjun and Gary Cohen, Health Management and Associates, shared section 1 and section 3 of the draft report to the Legislature, due November 2022. Section 1 covers a synthesis of analyses done on Washington's existing health care finance and delivery system and section 3 addresses the legislative requirement to create an inventory of the key design elements of a universal health care system.

Section 1 of the draft report focused on the issues in Washington's current health care system, as well as many of the policy responses developed to address them. According to the Washington State Office of Financial Management, the current uninsured rate is the lowest ever as a result of the ACA and work by the state to maintain and increase coverage for Washingtonians. However, the uninsured rate for some populations has increased, specifically for American Indian/Alaskan Native, Hawaiian and Pacific Islander, and Hispanic populations.

Health care costs have increased over time and are exceeding inflation and wage growth. Some of the policy responses to rising costs include the establishment of value-based payments, the Health Care Cost Transparency Board, the Prescription Drug Price Transparency Program, and the Prescription Drug Affordability Board.

In terms of health care workforce, the number of physicians in the state increased. However, physicians are disproportionally allocated throughout the state and are particularly concentrated in Chelan County. There are significant shortages in behavioral health and nurses. Hospital consolidation has also increased significantly.

The Universal Health Care proposed three models (Models A, B, and C) for universal health coverage in Washington. Ms. Arjun remarked that Washington is moving forward with implementation of Model C (access to coverage for undocumented immigrants) through a 1332 federal waiver.

Section 3 of the draft report focused on the design elements of a universal health care system. Eligibility and enrollment in the unified health care financing system is a consideration with a goal to cover every Washingtonian under a universal system. The covered benefits and services under the unified health care financing system will also need to be considered. Mr. Cohen raised considerations regarding whether essential health benefits, dentals, vision, and benefits mandated by Medicaid would be covered under the new system.

In terms of financing, it will be key to identify an approach to align or pool all funding sources to finance the benefits and services covered under the new system. One approach for consideration is the unified health care financing system could move away from a fee-for-service model and toward value-based payment models in order to encourage provider participation, as well as to improve quality and reduce health care costs. Mr. Cohen noted the importance of investing in administrative and operational capabilities to implement a cohesive model.

Mr. Cohen highlighted that in terms of governance, it will be important to ensure transparency and accountability for planning and implementing the new system. Additionally, the voice of consumers must be part of decision making.

Adjournment

Meeting adjourned at 5:00 p.m.

Next meeting

Thursday, June 16, 2022
Meeting to be held on Zoom
3:00 p.m. – 5:00 p.m.